



## Bridging to Preventive Care:

### *The Roadmap to Medicaid Coverage of Community-Based Chronic Disease Prevention & Management Programs*



### Executive Summary

The Illinois Public Health Institute (IPHI) works to optimize health, health equity, and quality of life for people in Illinois by mobilizing stakeholders, catalyzing partnerships, and leading action to promote prevention and public health systems. Over the past two years, IPHI, with its partners from the Illinois Alliance to Prevent Obesity (IAPO), has advocated for connecting community-based chronic disease prevention and management programs to Medicaid enrollees, especially to prevent and manage the impact of obesity and diabetes.

In April, 2016, IPHI/IAPO launched an intensive research and development effort to create a Roadmap for the essential elements required for offering evidence-based chronic disease prevention and management programs to Medicaid clients enrolled in managed care organizations (MCO). The following are the summary highlights needed to implement the key points of this effort.

### **Testing Ground: Demonstration Projects**

To initiate the Roadmap, the first phase is implementation of demonstration projects for adult chronic disease prevention and management programs, specifically the Centers for Disease Control (CDC)-recognized Diabetes Prevention Program (DPP) or the Stanford-developed Diabetes Self- Management Program (DSMP). While other programs exist, the efficacy of these two programs has been clearly established. Current inventory available for evidence-based programs for children and teenagers is very limited in Illinois. This Roadmap anticipates IPHI/IAPO convening a group to determine a course of action for children's programs in relation to Medicaid managed care.

Two key elements necessary for a demonstration project are:

- The Illinois Department of Health Care and Family Services (HFS) has strongly expressed its support. HFS has taken several steps to facilitate the initiative by allowing MCOs to attribute program costs to the Medical Loss Ratio. It has also indicated that community-

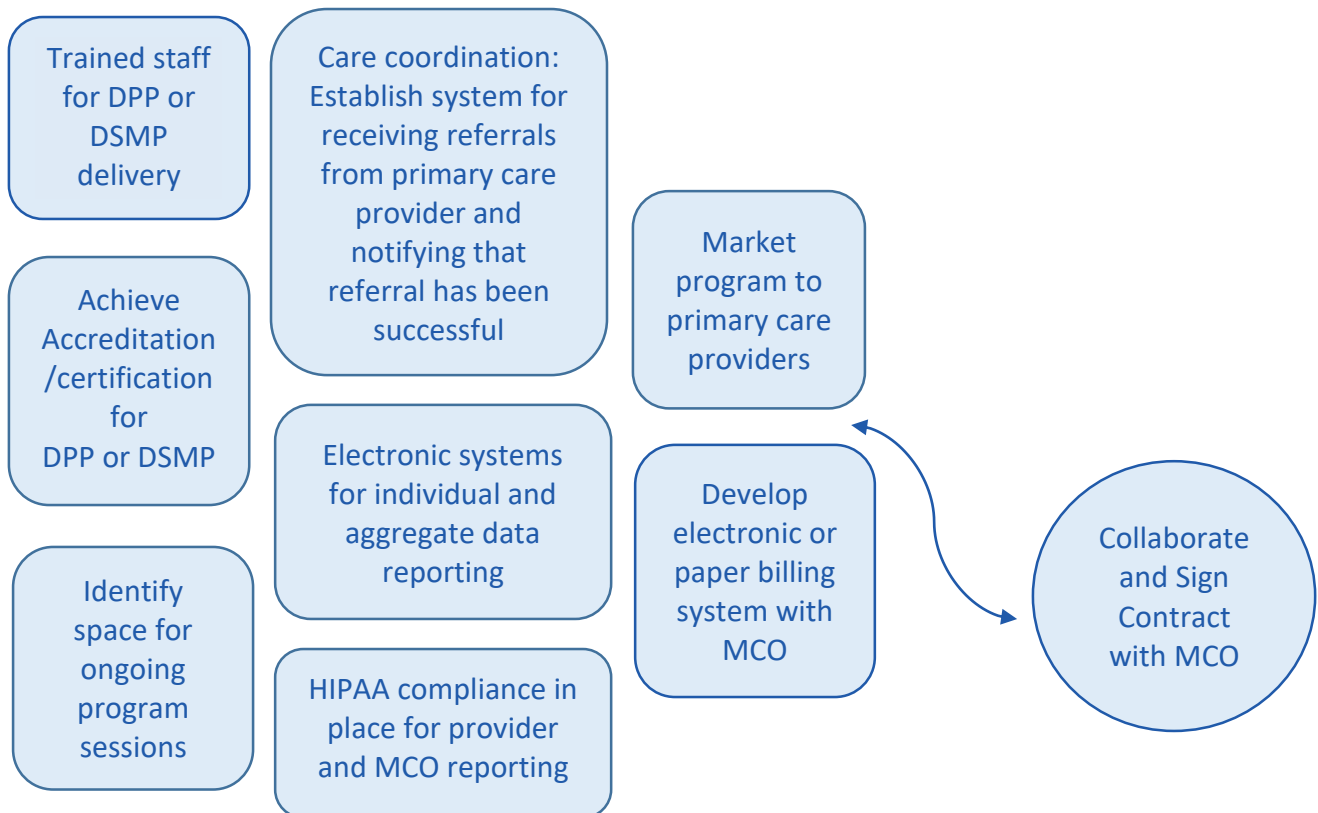


based organizations (CBOs) do not need to have a Medicaid provider agreement and will not need to report detailed information to HFS.

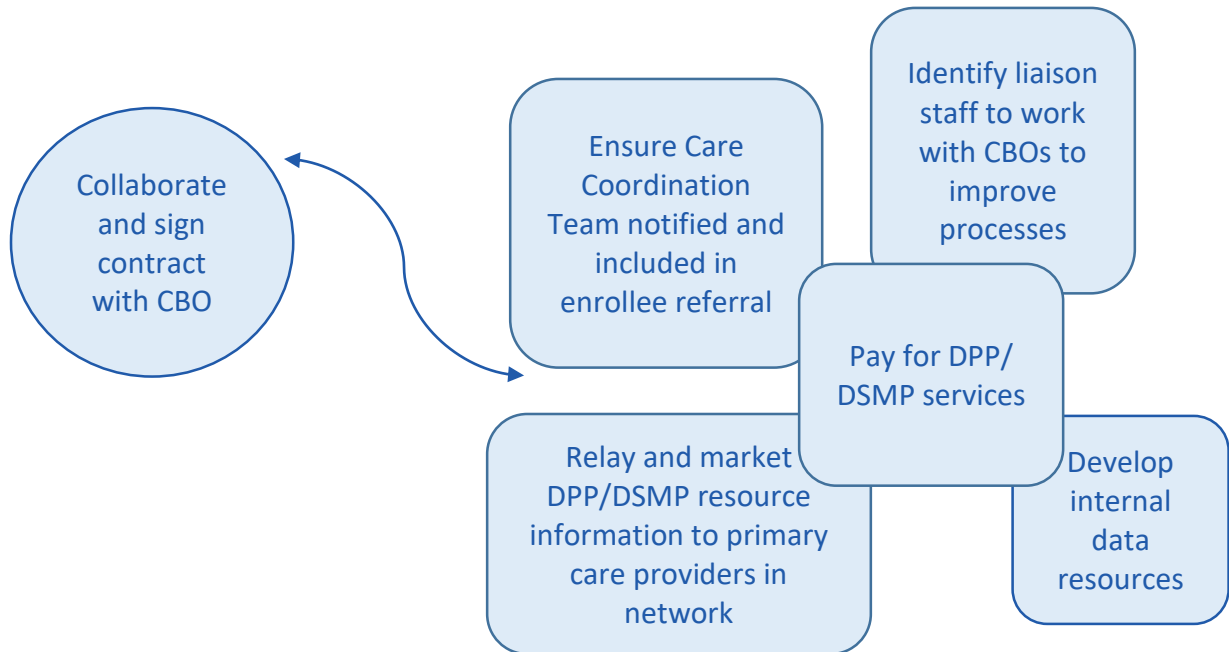
- While several organizations are working to become certified or accredited providers of these programs, at least two organizations, the YMCA and AgeOptions, have been working with DPP and DSMP, respectively, and can provide sufficient infrastructure to support demonstration projects in different parts of the state.

Still to be determined is an appropriate reimbursement model for the Medicaid population. While several models exist, balancing among start-up costs, uncertainties about successful enrollment for Medicaid enrollees, and CBO risk, a good model for the demonstration would be to reimburse on a per participant basis with most of the reimbursement for initial class attendance and a subsequent amount for program completion. Details would still need to be worked out as part of a contracting process.

**Readiness for the CBO pilot demonstration would include the following elements:**



**After negotiating the program contract, MCOs would primarily market the program as well as have the following key functions:**



It is important to note that the primary care provider and the consumer (Medicaid enrollee) are also integral to the success and impact of the initiative. The MCO and the CBO will have to cooperate closely to get these two partners aligned for this initiative’s successful implementation.

### **Assessment of demonstration phase**

The first phase: To be convincing, demonstrations should be established in Cook County and another location downstate to test the success of contracting, referral and programming processes. The goal is to establish the demonstration sites in early 2017. Periodic results from the evaluation in this first phase will help collaborators (CBOs/MCOs) make adjustments to improve efficacy. During the demonstration, additional CBOs and geographic areas should be identified for building new capacity and growing the initiative in the second phase.

- Technical assistance will be essential to ensuring successful implementation and continuing program assessment during this stage, as well as preparation for the second phase. About \$60,000 will be necessary to support the current consultants’ ongoing efforts into the beginning of the second phase.

The second phase: Results from the first year of the evaluation will trickle in during the year. But there should be sufficient information to start the second phase of program implementation no later than 12 months after the start of the demonstration. At that point, it should be possible to include lessons learned from the initial projects, including possibly expanding the nature of reimbursement to include clinical results.

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### **Creating a Continuum of Health for At-risk Illinois residents**

In an effort to optimize health for Illinois residents, the Illinois Public Health Institute (IPHI) has sought ways to create and improve connections between the evolving health care system and community and public health infrastructure. IPHI has collaborated with a number of other groups to create the Illinois Alliance to Prevent Obesity (IAPO), which focuses on preventing obesity through policy, systems and environmental changes. Over the past two years, IPHI and IAPO has worked with many partner organizations to envision a community-based system that focuses on prevention among Medicaid enrollees, especially for diabetes, obesity and other chronic diseases.

At the same time, the Illinois Department of Healthcare and Family Services (HFS), the state's Medicaid program, has been moving its primary delivery model to care provided by Medicaid Managed Care Organizations (MCOs). This is part of a nationwide trend to increase value in the provision of medical services. Consequently, a chronic disease prevention and management network needs to be fundamentally coordinated with the MCOs, since they are managing most Medicaid care. (See **Attachment One**).

IPHI/IAPO identified an initial framework that would allow Medicaid managed care organizations (MCOs) to offer chronic disease prevention and management programs to enrollees, specifically community-based programs that address prediabetes and diabetes management. The programs offered would be evidence-based, proven to be effective, and include models such as the Centers for Disease Control and Prevention-recognized Diabetes Prevention Program (DPP), and the Stanford-developed Diabetes Self-Management Program (DSMP) for adults, modified from Stanford's Chronic Disease Management Program, and the Mind, Exercise, Nutrition, Do It! (MEND) program for children. Most often these programs are not housed in clinical settings, but in churches, public health sites, YMCAs, and local fitness organizations. They are lifestyle interventions that effectively address issues of nutrition, fitness, weight-management, prescription management, mental health, and communication with a health care provider.

A large body of research has shown that programs such as the DPP and the DSMP can improve clinical outcomes and reduce costs, although the nature of the outcomes and savings vary on a variety of factors, including cost of intervention, age and other circumstance of participants, and participant adherence to the program.

## Developing a Roadmap for Community-Based Chronic Disease Management in Illinois

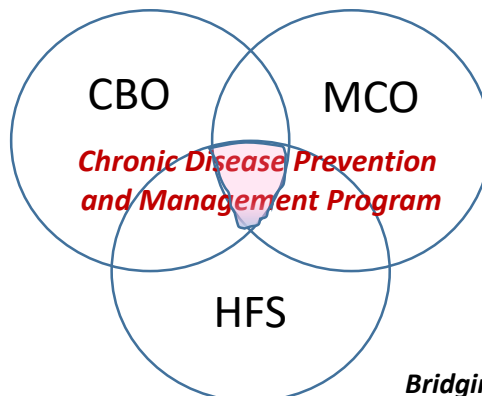
In the spring of 2016, IPHI began engaging stakeholders to explore how Illinois might begin to offer these cost effective interventions to Medicaid recipients – to create a “roadmap” for providing coverage of such programs. Early meetings with the Illinois Department of Healthcare and Family Services (HFS) secured their strong support for providing such coverage and developing a roadmap to reach that goal through managed care organizations. Additionally, the Illinois Association of Medicaid Health Plans also agreed to collaborate in exploring how these services could be offered through MCOs. IPHI identified additional stakeholders who endorsed the idea, including:

- Illinois Department of Public Health
- Illinois Chapter of the American Academy of Pediatrics
- Illinois Public Health Association
- Northern Illinois Public Health Consortium
- Illinois Association of Public Health Administrators
- Illinois State Alliance of YMCAs
- AgeOptions

Many of these organizations have a strong track record in offering prevention-focused programming for chronic disease conditions, both primary and secondary prevention, in community-based settings. The YMCA, for example, has been active both in directly providing these kinds of programs and in developing a national infrastructure for their provision. AgeOptions has been working to expand the Illinois infrastructure for the Chronic Disease Self-Management Program (CDSMP) and DSMP for the last 10 years through state and local grants.

Working with many of these stakeholders, IPHI received funding from The National Network of Public Health Institutes and the University of Wisconsin Population Health Institute County Health Rankings and Roadmaps program to engage stakeholders and hire a consultant to help advance this project. Funds from Michael Reese Health Trust also supported the effort.

The specific goal of the initiative was to develop the tools for collaborations between community-based organizations (CBO) and Medicaid MCOs to provide chronic disease prevention and management programs, such as those noted above.



## National Landscape for Community-Based Chronic Disease Management

It is well-recognized that diabetes and diabetes-related comorbidities have a significant impact on both the health of Americans and the cost of health care. The impact is particularly acute in Medicare and Medicaid. Nationwide an estimated 28% of all Medicare clients have diabetes, with the percentage higher among minority communities. For adult Medicaid clients, about 15% have diabetes, a portion of which are probably also Medicare clients (i.e. “dual eligible enrollees”). Diabetes, of course, also leads to a broad range of comorbidities such as heart disease and stroke, hypertension, blindness, kidney disease, and amputation. For youth, who account for about 45% of all Medicaid clients, increasing rates of obesity have led to increases in diabetes among this population, but also set the stage for larger increases later in life. In the face of such significant human and financial costs, there is a growing interest in programs that either prevent the development of diabetes or that improve the management of the disease once diagnosed.

Even with the growing interest, there is little experience in providing DPP or DSMP to Medicaid populations and particularly as part of managed care programs.

Patients with Medicaid based insurance face significant differences in diagnosis, treatment and intensity of their diabetes as compared to their Medicare and privately insured counterparts. Medicaid patients develop their diabetes at an earlier age with an increased level of severity and face significant socioeconomic concerns. Medicaid patients also have different health seeking preferences than their counterparts, impacted by technology use patterns and education preferences.

— Garfield et al, 2015

## National Medicare Policy and Coverage

### Diabetes Self-Management

Medicare has had some form of diabetes self-management education or training benefits for many years, but it is limited—both in the amount of diabetes education reimbursed and the type of health care professional whom can provide the training. A CBO can provide the program, but it must join with a Medicare medical provider who bills Medicare or obtains its own Medicaid number. Diabetes self-management programs vary, but have core elements and must be accredited to receive Medicare reimbursement. (This document focuses on the DSMP, which is a specific program developed by Stanford University.)

### Diabetes Prevention

Medicare has more recently experimented with providing DPP to assess its preventive impact and cost-efficacy. As a result of these demonstrations, Medicare recently announced the certification of DPP as a cost-saving program that reduced Medicare spending on the pre-



diabetic enrollee. This made DPP the first preventive service model certified for expansion from the Centers for Medicare and Medicaid Services Innovation Center (CMMI). DPP will soon be available for Medicare beneficiaries in 2018. However, details of the full implementation of this program are still being developed.

## **State-based Medicaid Policy and Coverage**

### **Diabetes Self-Management**

Medicaid interest in community-based chronic disease prevention is also on the rise. States have offered various diabetes self-management education programs (DSME). For example, in New York Medicaid has offered DSME for some time, but very few beneficiaries have taken advantage of it. Despite the low participation rate and its availability to fee-for-service (FFS) clients only, the program is believed to offer material savings. More recently, for instance, Mississippi and Colorado have added DSME programs to their covered benefits, but they are just starting to gather data on uptake and effectiveness.

### **Diabetes Prevention**

Currently, CDC, through the National Association of Chronic Disease Directors, is funding a demonstration in two states--Maryland and Oregon--to determine how DPP can fit into their Medicaid offerings. Those initiatives are just getting under way. Maryland has created a web site and has announced it will give grants to four MCOs to offer DPP and has created a website including DPP and DSME referrals in addition to community based alternatives for other chronic disease issues (<https://coaw.org/DHMH.Public/Home/Home.aspx/>). They will, apparently, be using an online program from Omada Health along with in-person delivery options. Oregon will use more community-based provisions of care, building on its plans for regional health collaboratives. A national nonprofit research Institute (RTI) will evaluate these initiatives, but it will be some time before results are available.

Other states known to be involved in DPP for Medicaid clients include Minnesota, which has offered DPP primarily through community health centers, and Montana, Iowa and New York. Montana Medicaid offered a prevention program for a number of years, and expanded materially through a grant from the CMS Center for Innovation. DPP was offered in hospital settings primarily and were taught by licensed professionals. This grant focused on the impact of using patient incentives to encourage participation in preventive care. It showed that with incentives Medicaid clients could achieve material improvements in health measures, although not as material as non-Medicaid participants in the program. Oregon and Maryland are currently exploring opportunities to expand DPP for Medicaid enrollees.

## **Opportunities to Expand Among At-risk Illinois Medicaid Enrollees**

Illinois Medicaid currently offers no adult preventive benefit for community-based pre-diabetes or diabetes self-management education. Medicaid-covered children may qualify for pre-

diabetes related education and nutrition support through the Early Periodic Screening and Diagnostic Testing (EPSDT) requirement.

To advance comprehensive community-based chronic disease prevention and management among Medicaid beneficiaries, IPHI launched a thorough planning process in April, 2016. Working with a broad range of stakeholders, IPHI convened a large meeting of community providers, managed care organizations, public health departments, and others to discuss how Illinois could combine Medicaid managed care with community delivery of diabetes prevention and self-management services. HFS, which emphatically supports this initiative, was also present. Several **workgroups** were established and met twice over the summer to assess the current situation and help develop recommendations for a specific roadmap. The following considerations emerged.

### 1. Illinois Medicaid prevalence of diabetes

Illinois currently has just under 3 million Medicaid enrollees, more than two-thirds of whom are enrolled in MCOs.

#### Estimates of Illinois Medicaid Managed Care Populations Diabetic or Obese/Overweight

	Adults		Pediatrics
<b>Diabetic</b>	175,000	<b>Obese</b>	100,000
<b>Overweight</b>	350,000	<b>Overweight</b>	200-300,000

*Based on national percentages applied to current Illinois Medicaid managed care enrollment.*

### 2. Managed Care and community-based prevention programs

MCOs face challenges in incorporating CBO-based programs into their model:

**Medicaid eligibility:** Medicaid creates challenges since eligibility is determined by poverty, which itself poses obstacles to healthy lifestyles. Moreover, clients can frequently lose eligibility—Illinois dis-enrolls about one-quarter of its Medicaid population each year—and in re-determination the MCO-enrollment can get shuffled so that clients end up in different MCOs year-to-year. In Illinois, this is compounded by the relative newness of Medicaid managed care and many of the MCOs are still working through start-up issues.

**Cost-benefit and quality measurement of a prevention benefit:** By design, MCOs focus on managing within a capitation. However, the impact of prevention programs is not felt immediately. Given the high degree of client shuffle among MCOs, the economic incentive for any given MCO is not always clear. It is also the case that, at this point, Illinois Medicaid has no specific incentive-generating quality measures for MCOs related to chronic disease



management or prevention programs, although some of the measures reflect certain clinical activities related to chronic disease, such as eye checks for patients with diabetes. There is an incentive for Body Mass Index measurement for children, but no requirement for Pay for Performance measures related to the programs discussed in this Roadmap.

**HFS support for implementation:** CBOs, MCOs and HFS recognize the value of community-based prevention and self-management models and are interested in developing viable models. HFS, in particular, has made its interest tangible by allowing MCOs to include costs of providing evidence-based CBO-sponsored programs in determination of the Medical Loss Ratio. HFS has also indicated that CBOs could provide services without having to be enrolled as Medicaid providers and would not have to provide detailed data to Medicaid on a client-by-client basis.

### 3. Community-based prevention opportunities

Broadly speaking, there are some immediate opportunities for implementation in community settings for adults in Medicaid, but this is not the case for Medicaid-eligible children--the supply of evidence-based pediatric programs is very limited.

#### a. Adult programs

While there are many potential providers including public health departments and park districts, there are two organizations in the state that have some experience with specific evidence based programs and geographic reach:

- [Illinois State Alliance of YMCA members: DPP](#)
- [AgeOptions Provider Network: DSMP](#)

Although neither of these has much experience with managed care—most of their efforts to this point have been grant supported--both are developing some infrastructure that can potentially be expanded state-wide. As such, they are key to the roadmap. Additionally, they have made progress in establishing bilingual programs, including the Cook County Department of Public Health collaboration with AgeOptions on DSM implementation in English and Spanish. AgeOptions also offers DSMP in Korean and Chinese. The YMCA offers DPP in both Spanish and English at specific locations, and can also deliver the program in Chinese and Portuguese.

The ease of getting programs up and running will vary across the state. For example, local YMCAs will offer DPP, with the national office providing technical and technological support. Some YMCAs in Illinois are much farther along than others in offering DPP. Working with a variety of CBOs and health departments, AgeOptions will have some areas ready to begin and others will need more time to operationalize. Their timeframe will depend on an array of tasks, including number of trained staff, identified space, and

accreditation. If a CBO wanted to go through the entire process of getting accredited in one of these programs, it could face a start-up time of up to a year.

#### b. Pediatric programs

There are very limited “evidence-based” programs for children’s weight loss, fitness, and nutrition programs currently offered in Illinois.

- **ProActive Kids** is a home-grown program, offered in partnership with hospitals in the Chicago suburbs, that appears successful. It uses a three meeting per week model which might be difficult for Medicaid families.
- The Illinois African American Coalition for Prevention offers **Healthier Choices, Healthier Families**, a program developed in consultation with the Sinai Urban Health Institute and the Consortium to Lower Obesity in Chicago Children. The Chicago Community Trust has funded the program for one year. They offer a combination of three evidence-based programs to small cohorts of families (8-12 per session): We CAN, Cooking Matters, and SPARK.
- Additionally, the national YMCA is considering adopting **MEND** as a child-friendly counterpart to its DPP initiative, but there are no pilots currently scheduled for Illinois.

The need for Medicaid to offer these programs is great. Slightly more than half of the children in Illinois are covered by Medicaid; more than one million children are in Illinois Medicaid managed care programs. As many as one-quarter of these may be obese or overweight. While the short-run savings from these programs is probably less dramatic than for adults, they will almost certainly improve long term health outcomes and therefore savings to the larger society. It may also be possible to use the EPSDT requirement to ensure some benefit.

#### 4. Referrals and Care Coordination

One of the central concerns raised by workgroups was how clients would be successfully referred to community-based programs.

##### a. Eligibility

**DSMP:** Diabetes diagnosis

**DPP:** Prediabetes, usually measured by a Body Mass Index of 25 or greater and A1C test value of 5.7 to 6.4 and no previous diabetes diagnosis

Eligibility for a diabetes self-management program, such as DSMP, is straightforward—the diagnosis of diabetes. Such information will be available to the Primary Care Provider (PCP), which includes the primary care provider and support staff in the medical home, any care coordination provided clients from some central location and in the MCO’s central data base. Clients with diabetes that are struggling to control their blood sugar levels and but are interested in engaging in their own care may benefit the most from DSMP.

For prevention programs, such as DPP, Medicare uses the definition of a BMI of 25 or greater and an A1c test with a value of 5.7 to 6.4 (or some tests that get at similar risk) and no previous diagnosis of diabetes. This is consistent with the recommendation of the U.S. Preventive Services Task Force. However, the Montana Medicaid program, based on its pilot demonstration, noted that a broader definition of pre-diabetes might be useful since the central goal is to keep people from getting to serious conditions and, with a younger population, even less serious specifics might indicate a troubling trajectory.

Regardless of specifics, MCOs believe that for both clinical and management control reasons, clients’ eligibility for a service must be confirmed by the PCP. This will constrain some of the self- and community-referral strategies used by CBOs, but MCOs and CBOs should work together to find ways of capturing this potential source of resources.

b. Enrolling clients

**Referral Coordination Options**

- 1) PCP refers directly to program and CBO will need to follow up for enrollment.
- 2) Central referral for all MCOs in an area and refer client to accessible location.
- 3) CBO works directly with PCP to identify potential enrollees

A successful referral will need to take into consideration barriers for the Medicaid enrollees including:

- the frequency of session,
- location and scheduling of program meetings,
- transportation options.

While some PCPs, such as federally qualified health centers, may have all the information available and be able to work through these issues with the patient, in most cases it is not possible to convert the PCP’s referral successfully without further support.



- In Option 1: The PCP refers directly to the program knowing the patient would benefit from a program, consults with the patient, gets consent, and informs the patient the program will contact him or her. Then the PCP would pass on information to the CBO which would in turn follow up with the patient, assess the patient's needs with regard to the program, schedule the patient and perhaps follow up further to insure attendance. **The primary benefit of this approach is that the initial contact is made by the PCP who can, among other things, assess the patient's readiness to actively participate in the program.**
- In Option 2: If more than one CBO operates in a geography, they could work together on developing a single referral coordinating center. MCO (s) could identify diabetic patients in a panel and refer them to the closest/preferred CBO. For people with pre-diabetes, providers would need to be involved and refer to the centralized system. Program coordinators could follow up with the potential enrollee. **The primary benefit of this program is a centralized referral system, simplifying the process for MCO and the PCPs.**
- In Option 3: The PCP works with a CBO to identify a cohort of patients who would be good candidates for the program. Then the CBO would take responsibility for contacting patients and getting them enrolled. The CBO and the PCP establish criteria for patient inclusion and look through patient panels to identify a group of patients that the CBO can attempt to recruit. **The primary advantage of this approach is that by identifying a large group of patients to recruit at one time, the odds are increased of getting an efficiently sized class much more quickly.**

In practice, the greatest success will probably come from combining two or all three of the above strategies, and perhaps include options for self-referral. The key will be to make sure the entire PCP organization and the MCO are working together with the CBO to maximize enrollment and support.

c. Opportunities for compounding impact of community-based programs

There is abundant evidence that the existence of community-based programs will not by itself result in referrals. [While the PCP is the key in making the initial referral and motivating the patient to enroll, it is also the case that surrounding programs with efforts to promote prevention and management programs will greatly enhance the outcomes.](#) (See **Attachment Two** for several useful resources on building concomitant community programs.)

5. Data and reporting

CBOs, park districts, and public health departments offering DPP will have to be capable of providing data at three distinct levels—individual information to the PCP, individual billing data, and aggregate data. These are further described in the following table:

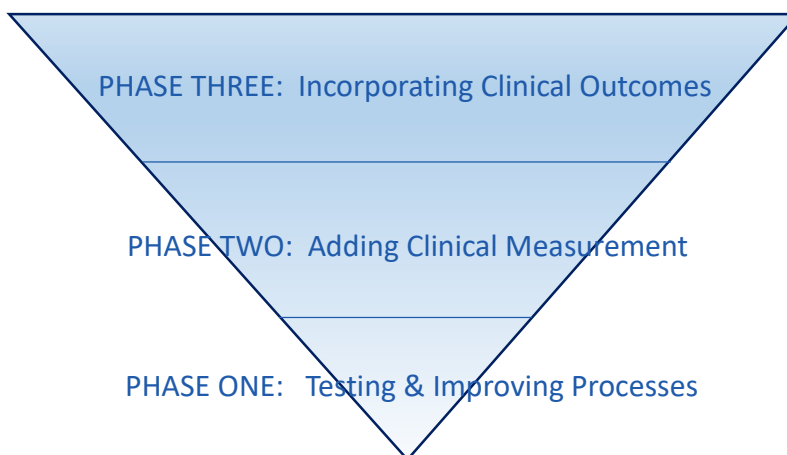
Data to PCP	Billing Data	Aggregate Data
<p>--Return information to PCP on which referred patients actually enrolled, how much they participated, and any specific information on the patient.</p> <p>--outcome data (e.g. weight loss) should be reported.</p>	<p>--Will depend on contractual provisions, but will have to include all the elements required for reimbursement, including client identification, participation, and any other data relevant to payment. Might be the same as the data reported back to PCP or at least include same elements.</p>	<p>--Overall program performance (e.g. how many referrals, how many converted to enrollees, degree of participation, any clinical outcome measures). Will be necessary for MCOs, possibly HFS, and most likely for some overall assessment of the entire initiative.</p>

While many potential program providers don't have the data systems in place ready for a pilot, two organizations are close or could begin a pilot with current data management tools. For example, the YMCA is working on a nation-wide system that will be ready in January 2017, and AgeOptions has computerized data management tool that tracks evaluation, referrals and infrastructure capacity. Other CBOs who opt to partner with these two groups would be able to meet these data reporting requirements while they develop more permanent solutions.

Related to the issue of data is HIPAA status. Generally speaking, if a CBO wants to receive payment for its services, it will have to be considered a HIPAA "covered entity," which requires compliance with a number of HIPAA determined steps health care providers must take. These raise difficulties—and a CBO would need to understand the issues before looking for reimbursement—but HIPAA should not ultimately be a reason for being unable to participate.

## Bridging to Preventive Care: Roadmap Recommendations

Given the promise and the challenges, what are the next steps? At the highest level, the process is to use a demonstration project to develop appropriate process and work flow and, as confidence is gained, and CBOs, MCOs and PCPs know how to recruit and retain patients, begin to look at the clinical outcomes and establish benchmarks for a return on investment.



More immediate steps for Phase One are as follows.

### Next Steps

1. Establish demonstration projects for adult DPP and DSM programs
2. Harvest experience from the pilot projects
3. Refine program operations and expand adult programs/Develop parallel programs to encourage enrollment, participation and follow up
4. Establish pediatric pilot program

1. Establish demonstration projects

To initiate the Roadmap, the first phase is implementation of demonstration projects for adult chronic disease management and prevention programs, specifically the Centers for Disease Control (CDC)-recognized Diabetes Prevention Program (DPP) or the Stanford-developed Diabetes Self- Management Program (DSMP).



- **Recommendation:** For demonstrations to be convincing, there should be at least two demonstration sites and they should get under way early in 2017.
- These should test different geographies and include both diabetes prevention and management programs. There will have to be a least one Chicago and one downstate site. The **Illinois State Alliance of YMCAs** thinks its providers in East St. Louis, the Quad Cities and West Suburban Cook County might be ready to offer prevention programs (DPP), but no specific discussions have been held. **AgeOptions** can confidently cover Cook County and are looking at ways to have accredited and HIPAA compliant sites with partners downstate. Other organizations, like local health departments, may also be available to provide DPP and DSMP services.
- **HFS** has done a number of things to simplify getting partnerships off the ground. HFS support, input, and assistance in setting up the demonstration projects will be essential to gaining MCO investment of time and energy. It may also be necessary to obtain HFS assistance in getting Medicaid provider numbers for CBOs since MCO data systems may not be able to readily pay CBOs if they don't have a provider number. (Over time, there may be more requirements for HFS actions, so their continued involvement and commitment is important.)

a. MOU/contracting process to initiate demonstrations

**Recommendation:** Use the draft framework (Attachment Three) or a similar contract that could jump-start negotiations between CBOs and MCOs. (See Attachment Four for Necessary Steps to Begin a Collaboration.)

There are two challenging issues to be resolved:

***Referrals and care coordination***

As discussed above, the referral models are for the CBO to establish some kind of referral center to which PCPs refer patients or for the CBO to work with physicians to identify potentially eligible patients.

**Recommendation:** CBOs must establish a successful referral system to operationalize a robust outreach and retention strategy. A successful strategy will require cultural competence and wherever possible should involve broader community efforts. (For instance, some health systems have undertaken or participated in community benefit programs focusing on diabetes. These should be used to leverage patient and physician participation in specific programs.)

***Reimbursement***

Ultimately, the reimbursement approach will depend on what can get negotiated between CBOs and the MCOs. MCOs have specifically asked for a simple reimbursement and billing system.



Given the considerable unknowns in providing these services to Illinois Medicaid clients, the most promising approach for the demonstration is partially modeled after the Medicare model.

**Recommendation:** a reimbursement model that allows the MCO to pay the CBO based on an enrollee’s participation. It could offer most of the reimbursement for attendance at the first class with a subsequent payment for completion of the program.

- Contracting with the MCOs is a simpler process than trying to contract with a large number of PCPs; this model avoids the issues associated with getting direct reimbursement from the State.
- While it retains some performance risk for the CBO in terms of enrolling clients and keeping them interested enough in the class to complete, it doesn’t put them at as much risk as if the reimbursement were heavily weighted to extensive participation or outcomes.
- As experience is gained, it will be possible to adjust the model to include more participation and outcome-related elements.

**(See Attachment Five** for several different reimbursement models and considerations.)

## 2. Harvest experience/data from the pilot projects

The success of the demonstration, which includes acceleration to expansion, will depend on cooperation from MCOs, support for CBOs, encouragement from HFS, and a mechanism to harvest learnings from the experience in real time and convert them into subsequent action steps. *Year One will be primarily concerned with testing the processes of implementing these programs—what are the best mechanisms for recruiting and retaining Medicaid patients and how to ensure successful referral patterns between CBOs and physicians.*

### Demonstration Goals

- Learn how Medicaid clients can be successfully recruited and motivated to participate
- Demonstrate contracting mechanisms—including CBO infrastructure and data communication practices
- Share best practices
- Facilitate expansion from demonstration programs to state-wide involvement by mid-2018

**Recommendation: Demonstration management and technical assistance will be essential during the pilot phase to ensure successful implementation and initial evaluation goals.**

There is currently no funding for such an effort, but depending on level effort, would cost at least \$50,000 and probably more. (See **Attachment Six**).

Getting started will take some time. After negotiating contracts, there will be a period where CBOs are working with MCOs and PCPs to implement referral processes, to reach a sufficient number of clients to begin offering classes, and make even a first determination of who is enrolling and who continues. The DPP lasts one year and the DSMP spans two months. A fuller sense of what works and what doesn't will not be possible until late in 2017 or even 2018.

Year Two or the second phase of the Roadmap will then focus on how to incorporate clinical data and perhaps outcomes. Some of this will be assessed in the initial phase, and perhaps where MCOs are willing to invest additional resources, other clinical data could be obtained. Given the current evidence showing that these programs produce better disease management, delay or prevent the onset of diabetes, it is reasonable to assume that initial data will suffice to encourage both MCOs and CBOs to continue and possibly expand the programs, but it will take longer and require a great degree of sophistication to measure clinical data and outcomes. Until the basic processes are reliably developed, trying to measure clinical outcomes may well be an unfair test of the potential of these programs.

3. Refine program operations and expand adult programs/ Develop parallel programs to encourage enrollment, participation and follow up

As experience is gained in actually going through the process, it will be possible to refine referral processes, work out contracting/data/billing glitches. There are compelling reasons to believe these programs will scale.

Even if it is possible to start a second wave of programs before the full results of the demonstrations are available, following clients all the way through the program will be an important learning process. It will be necessary to work with MCOs and perhaps HFS to see how involvement in either DPP or DSMP impacts client behavior.

There may also be a number of other issues that stem from completion of the demonstration projects. Some possibilities include:

- Making major changes in the reimbursement model
- Planning to include more clinical data in reporting
- Involving HFS more directly in the provision of these programs
- Finding ways of providing additional incentives for physicians to refer and patients to enroll and comply with recommendations

It may turn out that the “demonstrations” are not limited to the specific projects that are the first to get going. Individual MCOs and CBOs may start additional projects based on their own

needs or hopes. This would be very good in terms of getting more experience and, most importantly, getting more services to more people. If this happens, mechanisms should be developed to ensure that at least some common measures are used and that there is an overall repository for this data so that there is an ongoing overview of what does and does not work.

#### 4. Establish pediatric pilot

The issue of preventive programs for children in Illinois is particularly problematic. As noted above, there are very limited “evidence-based” programs for children’s weight loss, fitness, and nutrition programs currently offered in Illinois. Although such evidence-based programs for children exist, Illinois does not seem to have offerings ready to extend to children, especially in areas where Medicaid is the primary insurance coverage for children and an estimated 100,000 kids meet the definition of obesity. The specific focus of the first phase for chronic disease prevention among children will clearly need to focus on addressing obesity. [Recommendation: The Roadmap anticipates IPHI/IAPO convening a group to determine a course of action for children’s prevention programs in relation to Medicaid managed care.](#)

### Conclusion

This document reviews the current landscape and recommends moving forward with demonstration projects in which community based organizations would contract with Medicaid MCOs. Moving forward will require focused attention to get these demonstrations off the ground and then to show that programs already proven successful with other populations can achieve similar results with Medicaid managed care clients.

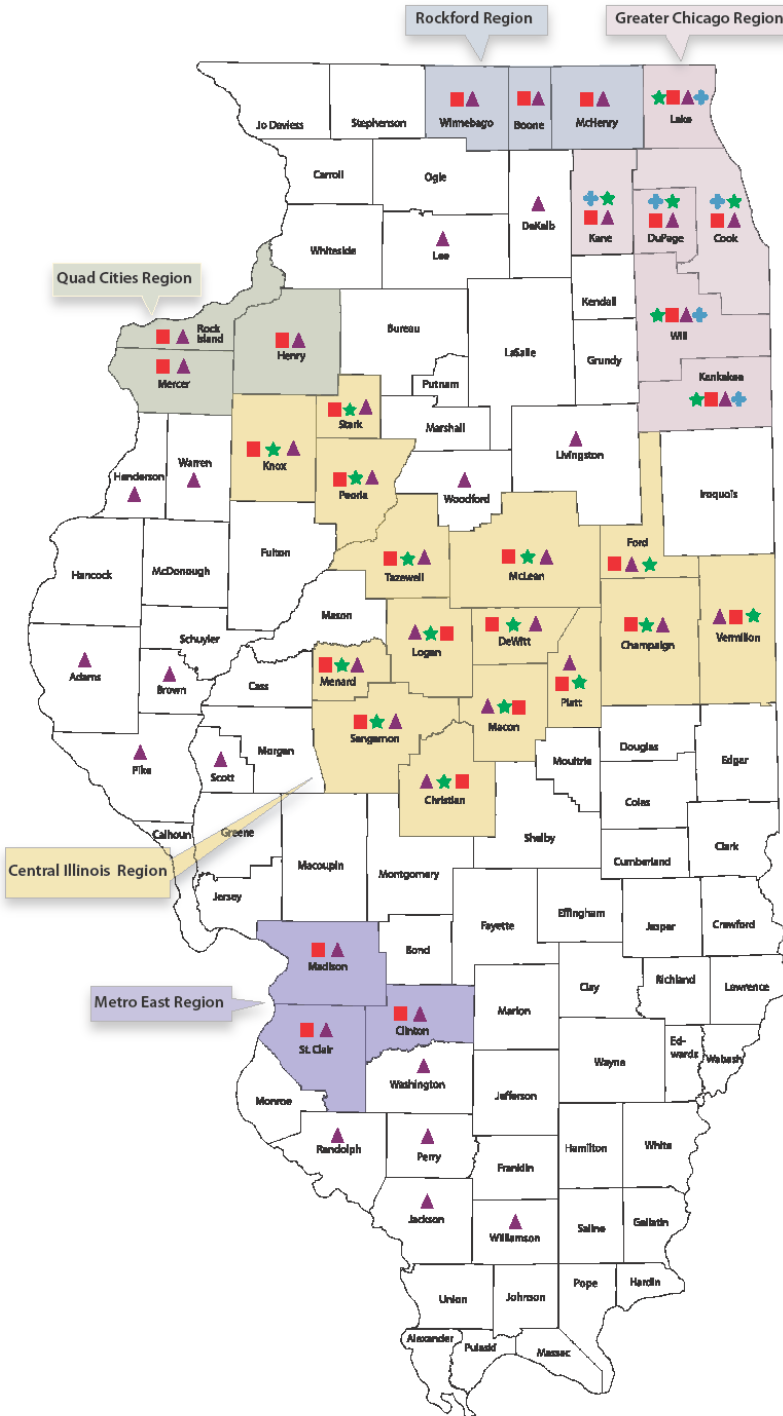
One part of achieving these results will be to take advantage of the community aspect of CBOs and, to the extent possible, embed specific DPP and DSMP classes in broader community initiatives. Churches, schools, public health departments, a wide range of community organizations and others need to be enlisted to work in broader campaigns to help persuade people of the importance of addressing these issues. Departments of public health might play a particularly important role. A broader community effort will improve take-up and completion rates, and subsequent adherence, for classes that are offered. Classes without external support are much less likely to achieve the ultimate desired goal of individual change.

While the Medicaid population comes with a number of challenges, the need is very great and the time is right for addressing them. There are enthusiastic community based organizations and cooperative managed care organizations and an extremely supportive Medicaid program to help shepherd this initiative forward.

ATTACHMENT ONE – A

Illinois Department of Healthcare and Family Services  
Care Coordination Map

July 1, 2016



Integrated Care Program (ICP)	
HEALTH PLAN NAME	
Aetna Better Health	Greater Chicago, Rockford
Blue Cross Community ICP	Greater Chicago
Cigna-HealthSpring	Greater Chicago
Community Care Alliance	Greater Chicago, Rockford
CountyCare	Greater Chicago (Cook only)
Health Alliance Connect	Central Illinois, Quad Cities
Humana Health Plan	Greater Chicago
IlliniCare Health	Greater Chicago, Rockford, Quad Cities
Meridian Health Plan	Greater Chicago, Central Illinois (Stark, Knox, Peoria and Tazewell counties only), Metro East
Molina Healthcare of Illinois	Central Illinois, Metro East
NextLevel Health	Greater Chicago (Cook only)

Family Health Plans/Affordable Care Act Health Plans (FHP/ACA) *	
HEALTH PLAN NAME	
Aetna Better Health	Greater Chicago, Rockford
Blue Cross Community Family Health Plan	Greater Chicago
CountyCare	Greater Chicago (Cook only)
Family Health Network	Greater Chicago
Harmony Health Plan	Greater Chicago, Metro East, Jackson, Perry, Randolph, Washington, Williamson
Health Alliance Connect	Central Illinois, Quad Cities, Rockford
IlliniCare Health	Greater Chicago, Rockford, Quad Cities
Meridian Health Plan	Greater Chicago, Central Illinois (Stark, Knox, Peoria, Tazewell and McLean counties only), Metro East, Quad Cities, Rockford, Adams, Brown, DeKalb, Henderson, Lee, Livingston, Pike, Scott, Warren, Woodford
Molina Healthcare	Greater Chicago (Cook only), Central Illinois, Metro East
NextLevel Health	Greater Chicago (Cook only)

Managed Long Term Services and Supports (MLTSS)	
HEALTH PLAN NAME	
Aetna Better Health Premier Plan	Greater Chicago (excluding Lake)
Blue Cross Community	Greater Chicago
IlliniCare Health	Greater Chicago
Meridian Complete	Greater Chicago (excluding Kankakee, Lake)

Medicare Medicaid Alignment Initiative (MMAI)	
HEALTH PLAN NAME	
Aetna Better Health Premier Plan	Greater Chicago (excluding Lake)
Blue Cross Community	Greater Chicago
Cigna-HealthSpring	Greater Chicago (excluding Kankakee)
Humana Health Plan, Inc	Greater Chicago
IlliniCare Health	Greater Chicago
Meridian Complete	Greater Chicago (excluding Kankakee, Lake)
Molina Healthcare of Illinois	Central Illinois

\*Illinois Health Connect will continue to be the health plan choice for most individuals residing in the non-shaded counties. In some counties, an individual may select an MCO health plan, if available, instead of Illinois Health Connect. Illinois Health Connect will also continue to assist individuals that are excluded from participating in a mandatory managed care program locate providers for health care services.

ATTACHMENT ONE – B

Illinois Medicaid Coordinated Care Enrollment				
By Program and MCO				
	Integrated Care Program	MMAI	Families/ACA	
<b>Greater Chicago Region</b>				
Aetna	27,290	6,363	144,838	
Blue Cross/Blue Shield	11,309	13,619	287,748	
Cigna	5,674	6,303		
Community Care	7,592			
CountyCare	4,603		147,956	
Family Health Net			217,817	
Harmony			134,520	
Health Alliance				
Humana	4,917	6,484		
IlliniCare/Centene	24,663	4,968	137,210	
Meridian	5,326	5,485	224,830	
Molina			91,620	
Next Level	4,143		29,108	
<b>Sub-Total</b>	<b>95,517</b>	<b>43,222</b>	<b>1,415,647</b>	
<b>Balance of State</b>				
Aetna	1,680		24,373	
Blue Cross/Blue Shield				
Cigna				
Community Care	1,474			
CountyCare				
Family Health Net				
Harmony			32,983	
Health Alliance	7,934		120,302	
Humana				
IlliniCare/Centene	2,521		34,183	
Meridian	6,284		121,828	
Molina	5,920	4,141	97,384	
Next Level				
<b>Sub-Total</b>	<b>25,813</b>	<b>4,141</b>	<b>431,053</b>	
<b>STATE TOTAL</b>	<b>121,330</b>	<b>47,363</b>	<b>1,846,700</b>	
<i>Source:</i> Map can be found on HFS website; it is updated periodically.				
Enrollment numbers are based on HFS website enrollment as of July, 2016,				
More information can be found at <a href="https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/FHPErollment.asp">https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/FHPErollment.asp</a> :				





## ATTACHMENT TWO: Supporting Community Programs

There is abundant evidence that the existence of community-based programs will not by itself result in referrals. While the PCP is the key in making the initial referral and motivating the patient to enroll, it is also the case that surrounding programs with efforts to promote prevention and management programs will greatly enhance the outcomes.

An excellent report put together by the National Association of Chronic Disease Directors describes a number of state wide initiatives to raise awareness of diabetes prevention and management approaches at both the community level and at the level of potentially prescribing physicians.

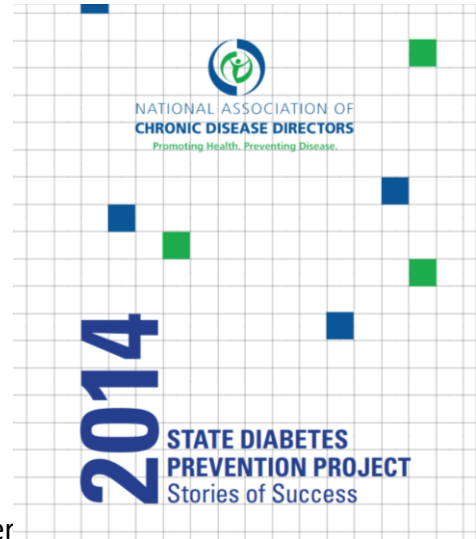
This included media campaigns, development of referral center designed to encourage referrals from physicians and tool kits to motivate impacted patients. This document can be found at:

[http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/NDPP/NACDD\\_State\\_Stories\\_Final\\_9\\_.pdf](http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/NDPP/NACDD_State_Stories_Final_9_.pdf)

There are other guides that are helpful. One focusing on community physical activities can be found at: <http://www.thecommunityguide.org/pa/campaigns/community.html>

A similar guide on community programs on obesity prevention can be found at: <http://www.thecommunityguide.org/obesity/communitysettings.html>

Steps of this variety are important to increase referrals. They will require participation of public health agencies, health care providers, CBOs of all varieties—including churches, and hopefully media. Efforts like these are already included in the community benefit plans of many hospitals and could be enhanced and coordinated around these efforts. It will also be important to take great pains to make messages culturally important since diabetes and diabetes-related problems are taking such great tolls in minority communities. (The above booklet gives several useful examples.)



## **ATTACHMENT THREE:**

### **Model Contract/Memorandum of Understanding Between Community Based Organizations and Medicaid Managed Care Organizations for the Provision of Preventative and Chronic Disease Management Services**

The Illinois Public Health Institute through its collaboration with the Illinois Alliance to Prevent Obesity is creating a roadmap to build a system covering community-based chronic disease prevention and management programs for Medicaid enrollees, specifically those enrolled in managed care organizations. Focus is on a series of evidence-based programs that educate enrollees about lifestyle changes, including exercise and nutrition guidance, and have demonstrated efficacy and efficiency. The provision of these services will encourage wellness and prevent morbidity and further onset of disease if diagnosed with a chronic illness.

In furtherance of this goal, we have developed the attached potential Contract/Memorandum of Understanding between a community-based organization (CBO) and a Medicaid Managed Care Organization (MCO). Ultimately, this might also take the form of a contract.)

The purpose is to create a document that both CBOs and MCOs can use to negotiate and commit to a package of service provision and payment for prevention and management of chronic disease. It assumed that in the negotiation of an agreement between two actual organizations details would be changed from this draft agreement. (On the other hand, it is also safe to assume that the more uniform the nature of agreements between CBOs and MCOs, the easier it will be for both parties to agree to and manage actual programs.

The particular document included here is a very first draft and has not been reviewed by CBOs, MCOs or the advisory council that has been assisting IPHI with this initiative. All of these will review the document and their input will be incorporated before a final document is promulgated.

**Contract/Memorandum of Understanding**  
**Between \_\_\_\_\_ [CBO provider]**  
**And \_\_\_\_\_ [Managed Care Organization]**  
**For the Provision of \_\_\_\_\_ Programs to Medicaid enrollees**

## **Purpose**

This Contract (hereafter, Contract) is made and entered into, by and between \_\_\_\_\_ [Managed Care Organization] hereafter referred to as “\_\_\_\_\_” and \_\_\_\_\_ [Community Based Organization, CBO] hereafter referred to as “\_\_\_\_\_”..

This Contract serves as the operating agreement between the parties for the purpose of providing and coordinating evidence-based programs, referred to hereafter as “the Program”, to Medicaid enrollees, hereafter referred to as “clients”.

## **General Terms and Conditions**

The purpose of this Contract is to formalize terms and conditions under which the parties shall work together to support the provision of services to the Medicaid populations enrolled in \_\_\_\_\_ (MCO). It outlines the following:

- 1) Program goals, description and qualifications
- 2) Program operations—duties of \_\_\_\_\_ MCO
- 3) Program operations—duties of \_\_\_\_\_ CBO
- 4) Billing and payment
- 5) Other reporting
- 6) Confidentiality of enrollee data
- 7) Indemnification
- 8) Term of Agreement and Renewal
- 9) General Administrative Terms



## 1. Program Goals, Description and Qualifications

- a. The purpose of this program is \_\_\_\_\_ (e.g. *diabetes prevention, management of diabetes after diagnosis*).
- b. The program accomplishes this through \_\_\_\_\_ (e.g. *weekly classes for six weeks, a regimen of classes over 12 months*)
- c. The underlying program has been developed by \_\_\_\_\_ (e.g. *Center for Disease Control, Stanford University*). Evidence of the effectiveness of this program in other settings can be found at \_\_\_\_\_. Fidelity to the original program is maintained by \_\_\_\_\_ (include information on source of curriculum, training of staff, and steps—such as certification of staff—that are taken to ensure that the program as offered has a high likelihood of replicating the original program that has been shown to be effective. Will need to be very specific on these steps, such as stating how staff training is certified, whether it applies to all staff members, etc.)

## 2. Program Operations—Duties of MCO

MCO will be responsible for identifying potential program participants and making a referral to the Program.

- a. MCO clients potentially eligible to participate in the program are those who \_\_\_\_\_ (specify terms by which clients are eligible; will presumably vary by the nature of the program offered, but in all cases eligibility criteria should be tied to established norms, such as those established by the USPSTF. Assuming that the number of programs—not sites, but programs such as DPP or Chronic Disease Management program—to be offered is not large, may make sense to simply standardize those criteria statewide.)
- b. MCO will identify these clients and communicate to the Program
  - 1) The names of the client—including other needed information (such as Medicaid ID)
  - 2) Contact information
  - 3) Reason for the referral
  - 4) Any other relevant information (e.g. comorbidities, prior history)
- c. MCO will communicate these referrals by \_\_\_\_\_. (Will need to be worked out as part of negotiations. May be as simple as faxing/e-mailing information to a Program designated receptor. Could be more elaborate, such as primary care physician and Program meeting to jointly review panels to identify candidates. May also depend on

*what degree of control MCO wants to maintain over referrals. For instance, it might adopt a process that referrals can come only from case coordinators, although, in any event, it seems the PCP should be involved.)*

- d. MCO warrants that if a referral is made following the referral process outlined in (c) above, the client is approved by the MCO for participation in the Program.
- e. MCO will take the following steps to make clinicians aware of the program:  
\_\_\_\_\_ *(Will depend on nature of actual referral mechanism, but at a minimum it will include substantial communication to primary care physicians and their office staff regarding the availability and nature of the Program.)*

### **3. Program Operations—Duties of the CBO**

CBO will be responsible for providing administrative and fiscal oversight of the Program, including for accepting referrals and registering potential participants into the Program

- a. Program will establish a point of contact and a process for all referrals.
- b. Program will be responsible for contacting potential clients and providing them with information about the Program (including the logistics of participation, such as time and place of sessions), and attempt to register clients for a specific offering. It will follow up with clients who agree but do not show for the first session.
- c. Program will notify referrer by \_\_\_\_\_ *(a mutually agreed upon process)* of which clients registered, which clients showed up for the first session, which clients declined to participate, and which clients could not be contacted.
- d. Program will offer program—including provision of appropriate space and appropriately trained staff—in accordance with the Program description. Program is required to communicate to the referrer a schedule of classes and locations and work with and MCO observer to plan in advance so the necessary approvals/release forms can be collected from all parties. MCO may send an observer at any time.
- e. Program will notify referrer by \_\_\_\_\_ *(a mutually agreed upon process)* of the degree of participation of patients who showed up for the first session, including any additional information available such as information about challenges patient experienced or outcome information such as weight changes.

## 4. Billing and Payment

*Billing of course, will be subject to subsequent negotiations. Below are some structural items that would have to be addressed regardless.*

- a. The Program will be responsible for billing the MCO on a monthly basis. Each bill must include the name (plus other required identifying information that the MCO provided for each patient), the dates of participation, and the amount billed. Bills should be sent to \_\_\_\_\_. The appropriate mode of billing is \_\_\_\_\_ (e.g. paper, electronic).
- b. The MCO will reimburse the Program as agreed within 45 days of the receipt of a clean claim. Payment should be sent to \_\_\_\_\_. The appropriate form of payment is \_\_\_\_\_ (e.g. check, electronic funds transfer).
- c. The MCO will be allowed to request back-up information on a reasonable percentage of clients for the purposes of verifying claims.
- d. The MCO will be responsible for payment (and the Program retain other duties as enumerated here) for any client who has been appropriately referred to a Program but who subsequently loses Medicaid eligibility or who switches health plan.

## 5. Other Reporting

In addition to information back to referrer and billing information, the Program agrees to make certain data available in an aggregate manner for evaluations, external and by MCOs.

- a. On a quarterly-basis, the Program shall submit to the MCO the following information on patients from that MCO and, if desired, aggregated information—excluding items (2) and (4) below—from all the Medicaid clients served by the Program regardless of MCO:
  - 1) Clients referred (including geographic markers)
  - 2) Source of client referral
  - 3) Degree of participation by referred clients (i.e. how many sessions did client attend)
  - 4) How programs delivered (i.e. which clients in which classes)
  - 5) Any outcome data available
- b. Data shall be submitted to \_\_\_\_\_ (*indicate where submitted and appropriate mode of submittal; likelihood is that it should be on a client by client basis with the ability to analyze, eg. Excel, Access, etc.*).



- c. Program shall have right to use all data on its clients, as otherwise appropriate, for research, marketing or fundraising purposes. Likewise, MCOs may use data, as appropriate, for research or marketing purposes.
- d. Program and MCO agree to make any data collected under this agreement available to researchers working with IPHI in the evaluation of the overall Bridging to Preventative Care initiative.

## 6. Confidentiality of Enrollee data and Health Insurance Portability and Accountability Act

*The issue of HIPAA is detailed and we are not the ultimate experts. Presumably the MCOs have legal departments more than sufficiently versed in HIPAA issues. However, based on our understanding, very little is explicitly required in this section beyond mutual assurances that all protected health information is subject to HIPAA and other Program and MCO are committed to their legal HIPAA responsibilities.*

*The relevant excerpt from the CMS explanatory language on HIPAA regulations would seem to be following:*

***A Business Associate Contract Is NOT Required*** when a health care provider discloses protected health information to a health plan for payment purposes.... A provider that submits a claim to a health plan and a health plan that assesses and pays the claim are each acting on its own behalf as a covered entity, and not as the “business associate” of the other (<http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/>).

*This same site also makes it clear that a business associate agreement is not needed for a circumstance in which one covered entity is making a referral to another covered entity.*

*One thing that could complicate these issues is if the CBOs did not consider themselves covered entities for the purpose of these programs.*

## 7. Indemnification

Each party shall defend, indemnify and hold harmless the other for its negligent acts or omission

## 8. Term of Agreement and Renewal

- a. This agreement will be effective \_\_\_\_\_ and will be in force for \_\_\_\_\_.  
*(Presumably something like one year. May want to establish common start and completion dates, especially during demonstration phase. See also discussion of renewal terms elsewhere.)*
- b. Because referrals put in motion a sequence of services, decisions about renewal should be made prior to 60 days before the expiration date—unless MCO and Program agree to other terms. If MCO and Program cannot reach agreement about renewal, all referrals will stop 60 days prior to the termination date or from 5 business days after the official decision to not renew, whichever comes later. The MCO will have no financial responsibility for referrals made after that date.
- c. MCO will remain responsible for payments as specified in this contract for all patients who were referred to the Program prior to the date established in (b) above.

## **9. General Administrative Terms**

*This spot is reserved for usual business boiler plate, e.g. official administrative contact.*



## ATTACHMENT FOUR: Steps to Demonstration Project Implementation

The following table summarizes the steps that are necessary for getting started with the demonstration, assuming a contract directly with an MCO. Most of the groundwork is required by the CBOs and, in all likelihood, YMCAs and programs working with AgeOptions. Other CBOs could participate if they believed they have capacity and access to evidence-based programs and the capability to negotiate contracts.

CBO	MCO
CBO, MCO, provider networks collaborate in geographic area to design potential scope and functioning	
<ul style="list-style-type: none"> <li>• Familiarity with specific program, including appropriate certifications/accreditation</li> <li>• Access to appropriately trained staff</li> <li>• Sufficient understanding of HIPAA to be compliant</li> <li>• Access to appropriate computerization</li> <li>• Ideas about how to get from PCP referral of client to client attendance</li> <li>• Clear ideas about much it would cost to both recruit clients and provide class</li> </ul>	<ul style="list-style-type: none"> <li>• Geographic presence</li> <li>• Understanding of patient population; identification of pre-diabetic and diabetic clients</li> </ul>
Develop contract (can follow Model Contract) <ul style="list-style-type: none"> <li>• Program being provided (DPP or DSMP)</li> <li>• How program fidelity is guaranteed</li> <li>• CBO and MCO responsibilities in recruiting clients</li> <li>• What data need be reported back to PCP</li> <li>• What data need be reported for billing/payment purposes</li> <li>• Amount/structure of payment</li> <li>• What data need be reported for aggregate reporting</li> </ul>	
Sign contract	Sign contract
Begin process of recruiting and enrolling clients	Work with CBO to develop sufficient pool of clients—including educating/motivating PCPs
Offer program—including some initial reporting to PCP (e.g. who showed, who didn't)	Involve Care coordination team for high-risk patients
Send bills to MCO at appropriate points	Pay bills
Subsequent reporting back to PCP	
Periodically report aggregate data to MCO	Analyze aggregate data to inform interactions
Develop mechanism for ongoing interactions with PCP to improve process efficiency	Work with CBOs and PCP to improve process efficiency
Work with whatever feedback/evaluation mechanisms in place to figure out how to expand	Work with whatever feedback/evaluation mechanisms in place to figure out how to expand
Determine under what circumstances would want to continue at end of contract	Determine under what circumstances would want to continue at end of contract
Negotiate renewal and expansion	

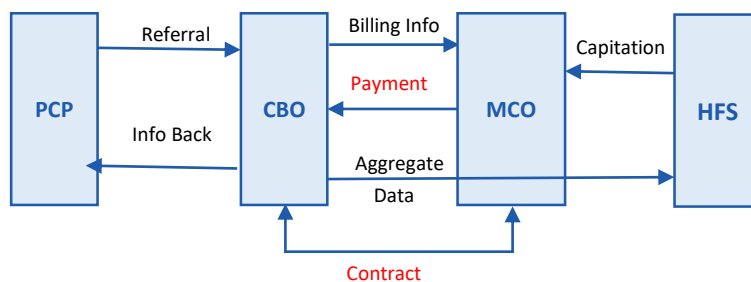
## ATTACHMENT FIVE: Additional reimbursement models

For the demonstration and long-term implementation, the most difficult issues around reimbursement are determining an appropriate reimbursement model—who pays and on what basis. The below outlines several possible models, including the elements that recommended for the demonstration projects—contracting directly with MCOs and with limited use of outcome data for the time being. Not shown below is a model that uses a third party entity for billing/payment and potentially even referrals.

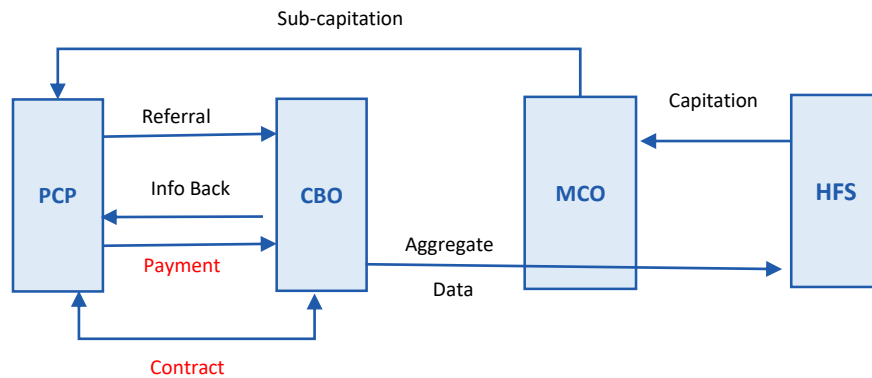
### 1. Who pays?

Generally speaking, there are three options—the MCO, the PCP or the State.

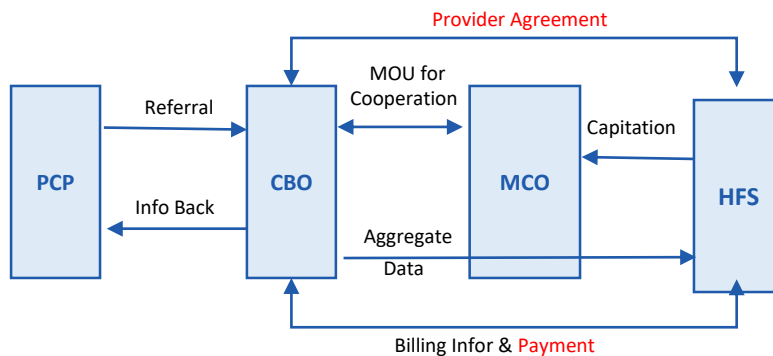
(a) The assumption throughout discussions so far has been that [the MCO would enter into a contract with one or more CBOs to provide services](#) to its clients in specific geographies and reimburse them accordingly. This model gives the MCO and the CBO a framework to work together to achieve optimal results and takes advantage of the relative flexibility of managed care arrangements to simplify the procedures. The biggest drawback to this approach is that it relies on the MCO to allocate part of its capitation to the CBO. While there is a logic to this approach, as described above, the MCO might find the payback time frame too long for actual on the ground situations and, as a consequence, be reluctant to contract at all for these services. The more upstream the prevention effort, the less immediate payback. The problem is particularly acute for pediatric programs.



(b) Another option is that the [CBO could contract directly with the PCP](#) in those circumstances where the PCP has a sub-capitation from the MCO—where the PCP gets a fixed amount to provide some services to clients. While this option has the potential to create greater cooperation between the PCP and the CBO in referring patients, it has a number of drawbacks. It only works where there is a sub-capitation (not the majority MCO reimbursement strategy in Illinois at the present time) and it significantly increases the complexity of contracting and data reporting requirements since presumably it would be necessary to contract with each PCP separately. The problem with aligning incentives could be more or less difficult depending on the orientation of the PCP.

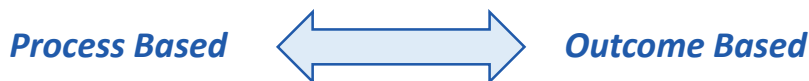


(c) The third option is to have the CBO bill the State directly. (This is apparently the option anticipated by Medicare with regard to provision of DPP.) This greatly reduces the problem of aligning incentives since the State has a broader set of concerns than short-term ROI. On the other hand, it would require CBOs to become more directly involved with the State—have a provider agreement with the State, meet State billing requirements, and so forth. Nor is it clear the State’s computer system is ready to accept such billing.



2. What should be the basis of reimbursement?

The fundamental question is to what degree should the reimbursement rest on achievement of certain outcomes. For DPP, for instance, Medicare will reimburse up to \$450 per client over a year, but about 41% of that amount is dependent on participant results, primarily weight loss. At the other of the spectrum is the kind of grant funding that has supported current DSMP and DPP programs in Illinois—a flat amount to the sponsoring organization to provide the program.



The first phase of the demonstration project will focus primarily on ensuring successful processes of PCP referrals and CBO receipt of referrals, securing contact with enrollees, and enrolling them in programs. The second phase will expand on any lessons learned. A sustainable program for Illinois Medicaid will, eventually, have to include a mix of process and outcome-based payments. Based on what is known about obstacles Medicaid enrollees often face in accessing health care in general, it is realistic that the payment model focus more on process than outcomes at least initially. Linking reimbursement to clinical outcomes could potentially complicate the reimbursement since it would presumably require the program participant to return to the PCP for clinical assessment. That is a good thing in itself, but it creates material additional complexity.

Having a portion of reimbursement directly linked to outcomes is important to achieve maximum value for program costs and will, presumably, be eventually incorporated. Depending on funding and MCO interest, even during the first phase of the demonstration projects it may be possible to do some initial assessment of health outcomes. Once PCPs refer patients to programs, they could schedule a follow-up appointment within a 3-6 month timeframe and assess certain health indicators at that time. These results could be compared with a similar cohort not receiving follow-up clinical care.

## ATTACHMENT SIX: Demonstration Infrastructure

As expressed in the report, it will be difficult for the demonstration to proceed in a timely and efficient manner without some technical and coordination assistance. This will include:

- Helping CBOs resolve their readiness issues
- Matchmaking between CBOs and MCOs as they work through contracting process
- Intermediate with HFS around either common or specific issues
- Troubleshooting problems as they arise
- Facilitate broader community involvement
- Assemble performance data into a meaningful overview—and use it to promote and motivate subsequent efforts
- Identify expansion opportunities, including pediatric efforts
- Facilitate group processes around moving into second wave

Costs for these efforts would depend on the extent of support anticipated and the strategy for obtaining.

**Time Frame:** October, 2016 through Early 2018 (i.e. beginning of second phase), about 18 months.

**Resource:** This is not at all a full time position, but will require fairly senior level attention, at least in part. Could be primarily a consultant, which would be more expensive but would get dedicated help. Could also be parts of senior and junior staff at some organization, but depends on having allocable staff available. Work will probably not be evenly distributed. Will have high load at beginning, moderate as actually underway, then pick up again going into expansionary phase. Minimum number of hours would be 350, which is an average of ½ day per week, with a pool of 15 days (120 hours) for special needs.

If consultant:

430 hours' x \$125/hour = \$53,750

Travel and miscellaneous = \$2,000

10% overhead for home organization supervision = \$5,575

TOTAL = \$61,325

If organization staff could contribute more hours on project:

300 hours' x \$50/hour = \$ 15,000

200 hours' x \$35/hour = \$ 7,000

Organizational overhead at 35% = \$ 7,700

Travel and miscellaneous = \$3,000

TOTAL = \$ 32,700